DOCUMENT RESUME

ED 439 342 CG 029 913

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TITLE Treating Stress across Cultures: A Somatic-Cognitive Model.
PUB DATE 1997-05-00
NOTE 7p.; In: Caring in an Age of Technology. Proceedings of the International Conference on Counseling in the 21st Century (6th, Beijing, China, May 29-30, 1997); see CG 029 879.
PUB TYPE Reports - Descriptive (141) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Cognitive Restructuring; Counselor Client Relationship; Relaxation Training; *Stress Management; Stress Variables; Travel
IDENTIFIERS Treatment Interaction Analysis

ABSTRACT

Acculturative stress or culture shock is a stress response that often occurs as individuals, especially students, travel and live in other countries. This paper describes a practical treatment model designed to help reduce the effects of this reaction. It states that the model is a comprehensive, integrative stress management treatment protocol that crosses cultural lines to address both somatic and cognitive responses. It is a short-term approach that can be employed in about six sessions. The major focus is on the therapeutic relationship with the client, the vehicle through which change is made possible. The key to effective treatment is the development of a trusting relationship between the counselor and client. It describes treatment of somatization as a tripartite process. The initial stage includes an in-depth assessment of physical signs/symptoms. The next stage involves a specific treatment for somatic anxiety in an attempt to achieve a relaxation response. The final stage involves a review of the previous sessions and the opportunity for the client to ask questions and receive feedback. The cognitive interventions are an adjunct to treatment. The paper argues that it is very important to explore the interplay of the client's thoughts, beliefs, and expectations with subsequent feelings and behaviors. This can be accomplished by a cognitive restructuring approach that examines the automaticity of certain thoughts. (Contains 13 references.) (JDM)

TREATING STRESS ACROSS CULTURES: A SOMATIC-COGNITIVE MODEL

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Introduction

"Acculturative stress," also referred to as "culture shock," is a stress response that often occurs as individuals travel and live in other countries. The culture of the individual exerts a strong influence on that individual's perceptions of, and responses to this stress. An integrative, rather than a culturally-specific approach to treatment, however, may afford the best results.

I will be describing a practical treatment model designed to reduce the effects of "acculturative stress." The model is a comprehensive, integrative stress management treatment protocol that crosses cultural lines to address both somatic and cognitive responses. It is a short-term approach that can be employed in approximately six sessions. The major focus is on the therapeutic relationship with the client--the vehicle through which change is made possible. There are also psychoeducational, cognitive, and behavioral components in the treatment model. The goal of treatment is to reduce the overall effects of culture-related somatic and cognitive anxiety.

INTRODUCTION

I will be describing a practical treatment model designed to reduce the effects of "acculturative stress," also referred to as "culture shock." Draguns (1981) refers to such effects as a "casualty of international mobility." This model has been developed from my work with myriad international clients at a mental health clinic in Washington, D.C., and with international student clients at counseling centers at several American universities.

The model is a short-term approach that can be employed in approximately six sessions. The major focus is on the therapeutic relationship with the client--the vehicle through which change is made possible. There are also psychoeducational, cognitive, and behavioral components in the treatment model. The goal of treatment is to reduce the overall effects of culture-related somatic and cognitive anxiety.

RELATIONSHIP BETWEEN CULTURE AND STRESS

"Stress" has more than forty definitions in the counseling literature (Hoes, 1986). One author goes so far as to say that the term "stress" is meaningless from a scientific standpoint (Averill, 1989). More specifically, acculturative stress is a "common, unavoidable process" (Zapf, 1991) that often occurs as individuals travel and live among non-native cultures. Such stress can impact immigrants, business people, students and scholars. Acculturative stress develops when "persons with histories of stability and with emotional and intellectual resources adequate for the task develop a wide variety of symptoms including restlessness, depression, irritability, loss of initiative, loss of appetite, and inability to concentrate. No two persons are the same" (Guthrie, 1979, p. 363).

Somatization (Somatic Anxiety)

A common stress response among non-Westerners is somatization--the subjective experience of physical symptoms in response to stress. Somatization is particularly prevalent in cultures that tend to discourage verbal expressions of emotional distress. Generally speaking, incidences of somatization increase as one travels east from the Eurocentric world.

The bulk of cross-cultural literature on somatization describes Asian samples, including the Near East, Far East, and Pacific Rim. In Western Asia and the Middle East, physical symptoms tend to be more acceptable than psychological symptoms, with less associated stigma. This phenomenon was described by Meleis (1982) and Silver (1987) when they noted striking similarities between Arab Muslims and Israeli Jews. Other peoples from such otherwise diverse cultures as Africa and South America experience frequent somatic reactions, especially where physical complaints are generally seen as acceptable responses to stress.

Cognitive Anxiety

The cross-cultural literature also describes cognitive anxiety as an acculturative-stress response. Walton (1990) refers to "cognitive inconsistencies" experienced by those who travel between cultures. Bombardment by new and conflicting expectancies creates cognitive distortions and anxiety. These cognitions may include worries about "not having what it takes to handle things. . . . how difficult or punishing my tasks are. . . . the outside demands and pressures in my way. . . . how complicated things are. . . . how uncertain things are. . . . unmet needs and wishes. . . . taking things too seriously [and not seeing] things in perspective. . . . [and] worry itself" (Smith, 1989, pp. 43-45).

It is important to remember that the above-mentioned "symptoms" are common acculturative reactions and, in and of themselves, are not pathological.

THE THERAPEUTIC RELATIONSHIP AND ASSESSMENT

The initial session(s) for treatment of acculturative stress consists of an in-depth intake with a strong psychoeducational component. It is important that the client knows what to expect from this process. An initial assessment of client expectations is followed by a detailed description of the treatment process. Clients often come to counseling needing "to be fixed," and with expectations of significant action on the part of the counselor.

A vital initial step is to convey to the client the importance of communication and trust--"We must first get to know each other." Equally important is "learning from the client," a process during which many questions are asked and the therapeutic bond strengthens.

The counselor should ask about the values, relationships, and cultural expectations of the client in an unassuming, sensitive manner. What were the client's expectations about the new land? Are these expectations being met? Have they changed? How does life "back home" compare with life in this new place? How has the client sought to relieve anxiety in the past? Has the client had "previous treatment?" These questions yield important diagnostic and treatment-related information.

There are a number of important areas to explore as part of the extended intake. Language difficulty is a good starting place since it is often a primary stressor. The client, for example, may have discovered that an ability to speak the new language does not necessarily translate into an ability to understand the language upon hearing it. A referral to a language tutor may initially be an effective anxiety-reducing agent.

Relationship expectancies and interpersonal communication styles are important to discuss. Some societies promote very close peer bonds, for example, while others may foster more loose "acquaintanceships." What makes life meaningful and enjoyable for the client? Is that missing in the client's new life?

The current social network of the client needs to be assessed. Individuals, for instance, whose primary interaction is with others from their own culture, may yield chronic alienation from the new culture.

The client may have been affected by incidents of discrimination or racism. These occur much more frequently than one may assume. Heikenheimo and Shute's (1986) study of international students revealed that nearly 90% had experienced discriminatory behaviors. Others, such as refugees, may have experienced traumas that require more than six sessions of therapy.

Gender issues warrant attention, particularly for females. Gender issues may also affect males, however, such as those who have been accustomed to female subservience, and now need to be aware of differences in expectations in their new environment. Again, comparing and contrasting the client's native culture with the new culture is helpful.

There are a number of other differences across cultures which may contribute to acculturative stress. An example is the concept of time, which tends to be a much more concrete paradigm in the West. Another example involves the concept of work, where differences may lead to issues concerning cooperation and/or competitiveness.

As all of these issues are explored, a trusting relationship between counselor and client is developing, the key to effective treatment.

TREATMENT INTERVENTIONS

Somatic Anxiety

The treatment of somatization is a tripartite process. The initial stage includes a "somatic check-up," which is actually an in-depth assessment of physical signs/symptoms. This can be accomplished using a modified medical-model approach. The client's physical discomfort needs to be assessed via a thorough history. (If symptoms indicate, a physical examination by a health care professional may be warranted). Organic causes of somatic discomfort must be ruled out.

The next stage involves a specific treatment for somatic anxiety. This may vary according to counselor preference. The treatment goal here is to produce a decrease or absence of somatic distress, ideally yielding what Budzynski (1978) refers to as a "Relaxation Response." For many Western-trained counselors, Progressive Muscle Relaxation (Jacobson, 1934) is a familiar, effective approach. This technique teaches the client to achieve somatic relaxation and relief through a series of muscle tensing-relaxing exercises. This process is also helpful for many clients because they become an active participant in their own treatment. An audiotape for between- session follow-up can be an effective adjunct.

The final stage of the somatic treatment sessions simply involves a review of the previous sessions and the opportunity for the client to ask questions and refine his/her techniques. Counselor feedback provides the client with a sense of mastery, promoting confidence in self, as well as in the counselor.

Cognitive Anxiety

The cognitive interventions, like the somatic treatment elements, are an adjunct treatment, "part of the whole," as it were. It is very important to explore the interplay of the client's thoughts, beliefs, and expectations with subsequent feelings and behaviors. Beck's (1979) model of cognitive restructuring is a good example. The goal here is not to alter the client's cultural belief system. Rather, it is to identify and mediate conflicts between the client's present cognitions and present life situations.

This can be accomplished by employing a cognitive restructuring approach, particularly one that examines the automaticity of certain thoughts. The individual learns to recognize the cause of the unwanted stress, and then learns to control and reduce that stress. Consider, for example, the case of an international student who has become anxious and distressed. The student has begun to struggle academically, and has automatically concluded, "I am a failure." Working with the client to identify the cause of the anxiety, and then identify alternative, rational responses to that cause allows the client to recognize options, to learn more of the host culture, and ultimately to experience a decrease in cognitive anxiety.

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